SENATE BILL REPORT
SB 6328

As of January 26, 2004

Title: An act relating to establishing a supplemental malpractice insurance program.

Brief Description: Establishing a supplemental malpractice insurance program.

Sponsors: Senators Deccio, Winsley, Kline, Brown, Rasmussen and Franklin; by request of Insurance Commissioner.

Brief History:
Committee Activity: Health & Long-Term Care: 1/28/04.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Tanya Karwaki (786-7447)

Background: There is concern about rising medical malpractice insurance costs. Excess insurance increases coverage beyond the primary limit of coverage. Other states that have excess insurance programs for medical malpractice claims include Indiana, Kansas, Louisiana, Nebraska, New Mexico, Pennsylvania, South Carolina and Wisconsin.

Summary of Bill: A supplemental malpractice insurance program (SMIP) is created to provide an excess layer of liability coverage for medical malpractice claims.

The program is a distinct legal entity, not an insurer nor a state agency. The state is not liable for any debts or obligations of the program.

A board of governors oversee the program and the board's composition is specified. Within 60 days of the board's appointment, the board must adopt a program plan of operation.

The program must charge an annual premium to participants and use this money to pay claims, administrative costs, and other expenses. The program is authorized to issue a capital call to increase its surplus but must have the Insurance Commissioner's approval based on specified criteria before issuing the capital call.

The program must file an annual statement with the commissioner with information about the past calendar year, including information about the program's transactions, financial condition, and operations.

Participation in this program is voluntary but to be eligible for participation, a facility must be located in Washington, be licensed by Washington, or be ending business operations afer January 1, 2005, and needing to buy tail coverage. A health care provider is eligible to buy coverage if: he or she is licensed by Washington and maintains a principal place of practice in Washington; the provider's principal place of practice is Idaho or Oregon and the provider is a resident of Washington and licensed by Washington and performs procedures in Idaho or Oregon; the provider retires or ceases business operations after January 1, 2005, and needs to

buy tail coverage; or the provider is a federal employee or contractor covered by the Federal Tort Claims Act and practicing outside of the exclusion that would otherwise apply to such a provider.

The program does not cover facilities or providers that do not meet the criteria for eligibility or that do not provide proof of financial responsibility. Additionally, the program does not cover federal employees or contractors covered by the Federal Tort Claims Act who are acting in the scope of their employment, or facilities operated by the state or federal government.

Financial responsibility requirements are established. The minimum limit for providers is $250,000 per claim and annual aggregate limits of $750,000. For facilities the minimum limit varies based on the size and provision of surgical services. The program must establish alternative rates for facilities or providers who elect to maintain higher retained limits.

Insuring entities or self-insurers providing medical malpractice insurance in Washington must offer limits of coverage equal to the minimum financial responsibility requirements and must pay attorney fees and costs incurred in the settlement or defense of any claim, as well as any settlement, award, or judgment subject to the terms and conditions of the insurance policy.

The limits of the excess insurance under the program are: $1 million per claim and an annual aggregate limit of $3 million for providers; $2 million per claim and an annual aggregate of $6 million for health care facilities. The program must offer higher limits of coverage to providers and facilities willing to purchase them.

From January 1, 2005, through December 31, 2005, the annual program premium is determined by the commissioner based on an analysis of rates, rating plans, and claims experience for medical malpractice insurance, as well as other relevant factors. Beginning January 1, 2006, the board must contract with an actuary to develop premiums. Specific factors must be considered when establishing rates and a rating plan. The commissioner's staff must independently evaluate the rates and rating plan and agree that they are reasonable before they become effective.

Providers and facilities must pay a premium to be covered by the program. The premiums are collected by the insuring entity and then paid to the program.

A facility or provider may not reject any settlement agreed to between a claimant and the program or an insuring entity or self-insurer providing the underlying insurance. A facility or provider may appeal to the board if such a settlement results in a premium increase and the facility or provider believes the claim was without merit.

The program must be notified when a loss reserve is established for a claim that exceeds $125,000. The program may participate in the defense of the facility or provider.

Beginning March 1, 2005, all medical malpractice insurers or self-insurers providing coverage in Washington must report to the commissioner any claim resulting in a final judgment, settlement, or disposition resulting in no payment. The data that are to be in the report are established. Violations of this reporting provision may be subject to a fine of $250 per day, not to exceed $10,000. The commissioner must prepare and make available statistical summaries of the data reported. Beginning in 2006, the commissioner must prepare an annual

report summarizing and analyzing the data reported and the annual financial reports of insurers.

The commissioner is authorized to adopt all rules necessary for implementation.

The Department of Health must investigate a health care professional if he or she has three claims paid in the last five years, each equal to or exceeding $50,000.

$10 million is appropriated from the health services account to the Department of Health to provide capital and surplus to the program and to pay the administrative costs incurred in establishing the program.

Appropriation: $10 million is appropriated from the health services account to the Department of Health.

Fiscal Note: Requested on January 23, 2004.

Effective Date: The bill contains an emergency clause and takes effect immediately.